FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020842

Facility Name: HALSTED TERRACE NSG CTR INC.

Address: 10935 S. HALSTED (Number) CHICAGO (City) 60628 (Zip Code)

County: COOK

Telephone Number: (773) 928-2000 **Fax #** (773) 928-9154

IDPA ID Number: 362877032001

Date of Initial License for Current Owners: 05/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	52,765	3,437	4,321	60,523	8
9	SNF/PED					9
10	ICF	37,419	1,683	128	39,230	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	90,184	5,120	4,449	99,753	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.10%

D. How many bed-hold days during this year were paid by Public Aid?
2,162 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 3,675

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	273,892	35,290	13,071	322,253		322,253	4,995	327,248			1
2	Food Purchase		457,452		457,452	(33,690)	423,763	(235)	423,528			2
3	Housekeeping	335,912	66,458		402,370		402,370	15,363	417,733			3
4	Laundry	52,520	39,788		92,308		92,308		92,308			4
5	Heat and Other Utilities			197,895	197,895		197,895	4,513	202,408			5
6	Maintenance	96,267	9,722	105,188	211,177		211,177	(6,548)	204,629			6
7	Other (specify):*											7
8	**TOTAL General Services**	758,591	608,710	316,154	1,683,455	(33,690)	1,649,766	18,088	1,667,854			8
	B. Health Care and Programs											
9	Medical Director			21,800	21,800		21,800		21,800			9
10	Nursing and Medical Records	3,158,710	280,350	9,960	3,449,020		3,449,020	(26,812)	3,422,208			10
10a	Therapy	129,672		4,606	134,278		134,278		134,278			10a
11	Activities	198,913	12,233	2,400	213,546		213,546		213,546			11
12	Social Services	94,957		3,076	98,033		98,033		98,033			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,582,252	292,583	41,842	3,916,677		3,916,677	(26,812)	3,889,865			16
	C. General Administration											
17	Administrative	284,085		540,000	824,085		824,085	(474,334)	349,751			17
18	Directors Fees											18
19	Professional Services			619,077	619,077		619,077	(364,804)	254,273			19
20	Dues, Fees, Subscriptions & Promotions			198,953	198,953		198,953	(156,529)	42,424			20
21	Clerical & General Office Expenses	277,052	2,728	385,589	665,369		665,369	(74,928)	590,441			21
22	Employee Benefits & Payroll Taxes			831,612	831,612	33,690	865,302	(1,484)	863,818			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,425	1,425		1,425	2,460	3,885			24
25	Other Admin. Staff Transportation			1,921	1,921		1,921		1,921			25
26	Insurance-Prop.Liab.Malpractice			240,154	240,154		240,154	36,870	277,024			26
27	Other (specify):*							68,836	68,836			27
28	**TOTAL General Administration**	561,137	2,728	2,818,731	3,382,596	33,690	3,416,286	(963,913)	2,452,372			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,901,980	904,021	3,176,727	8,982,728		8,982,728	(972,637)	8,010,091			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. #0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			135,023	135,023		135,023	515,233	650,256			30
31	Amortization of Pre-Op. & Org.							10,405	10,405			31
32	Interest			237,066	237,066		237,066	562,002	799,068			32
33	Real Estate Taxes							237,190	237,190			33
34	Rent-Facility & Grounds			1,316,477	1,316,477		1,316,477	(1,314,000)	2,477			34
35	Rent-Equipment & Vehicles			33,675	33,675		33,675	(14,782)	18,893			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,722,241	1,722,241		1,722,241	(3,952)	1,718,289			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	132,716	171,016	46,319	350,051		350,051	(66,552)	283,499			39
40	Barber and Beauty Shops			1,320	1,320		1,320		1,320			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*	107,495			107,495		107,495	(107,495)				43
44	**TOTAL Special Cost Centers**	240,211	171,016	211,889	623,116		623,116	(174,047)	449,069			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,142,191	1,075,037	5,110,857	11,328,085		11,328,085	(1,150,636)	10,177,449			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	285,161	30		9
10	Interest and Other Investment Income	(33,475)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(235)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,154)	21		18
19	Entertainment				19
20	Contributions	(36,281)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(278,198)	21		24
25	Fund Raising, Advertising and Promotional	(129,640)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(300)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,946)	20		28
29	Other-Attach Schedule	(311,685)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (516,753)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(633,883)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (633,883)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,150,636)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HALSTED TERRACE NSG CTR INC.

ID# 0020842

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (10)	21	1
2	Veterans - Miscellaneous	(663)	10	2
3	Veterans - Pharmacy	(25,969)	10	3
4	Officers Life Insurance	(1,484)	22	4
5	Therapy Settlement	(66,552)	39	5
6	Wage Assignment Income	(180)	10	6
7	Halsted Terrace Associates - Accounting	(4,692)	19	7
8	Halsted Terrace Associates - Trust Fees	(375)	21	8
9	Halsted Terrace Associates - Replacement Tax	(3,960)	21	9
10	Marketing Salary	(107,495)	43	10
11	Non-Care Asset - Depreciation Expense	(4,024)	30	11
12	Non-Allowable Seminar Expense	(179)	24	12
13	Capitalized R&M Expense	(10,992)	06	13
14	Management Fees - Bernard Cohen & Associates	(60,000)	17	14
15	Non-Allowable Auto Leases	(17,686)	35	15
16	Non-Allowable Auto Lease Insurance	(5,217)	26	16
17	Non-Allowable Legal Expense	(2,207)	19	17
18				18
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				4,995								4,995	1
2	Food Purchase	(235)											(235)	2
3	Housekeeping				15,363								15,363	3
4	Laundry													4
5	Heat and Other Utilities				4,513								4,513	5
6	Maintenance	(10,992)			4,444								(6,548)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(11,227)			29,315								18,088	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(26,812)											(26,812)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(26,812)											(26,812)	16
	C. General Administration													
17	Administrative	(60,000)		(31,463)		(208,406)	(174,465)						(474,334)	17
18	Directors Fees													18
19	Professional Services	(6,899)	4,692	1,411	(367,617)	3,609							(364,804)	19
20	Fees, Subscriptions & Promotions	(169,867)		11,418	1,920								(156,529)	20
21	Clerical & General Office Expenses	(290,997)	4,335	3,560	205,785	2,217	172						(74,928)	21
22	Employee Benefits & Payroll Taxes	(1,484)											(1,484)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(179)		42	2,597								2,460	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(5,217)	41,230		857								36,870	26
27	Other (specify):*			7,052	57,028	4,509	247						68,836	27
28	**TOTAL General Administration**	(534,643)	50,257	(7,980)	(99,430)	(198,071)	(174,046)						(963,913)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(572,682)	50,257	(7,980)	(70,115)	(198,071)	(174,046)						(972,637)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	281,137	208,205		25,891								515,233	30
31	Amortization of Pre-Op. & Org.		10,129		276								10,405	31
32	Interest	(33,475)	555,989		39,488								562,002	32
33	Real Estate Taxes		228,301		8,889								237,190	33
34	Rent-Facility & Grounds		(1,314,000)										(1,314,000)	34
35	Rent-Equipment & Vehicles	(17,686)			2,904								(14,782)	35
36	Other (specify):*													36
37	TOTAL Ownership	229,976	(311,376)		77,448								(3,952)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(66,552)											(66,552)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(107,495)											(107,495)	43
44	TOTAL Special Cost Centers	(174,047)											(174,047)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(516,753)	(261,119)	(7,980)	7,333	(198,071)	(174,046)						(1,150,636)	45

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Halsted Associates		Bldg. Partnership

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,314,000	Halsted Terrace Associates	100.00%	$	$ (1,314,000)	1
2	V	32	Interest Income	62,512	Halsted Terrace Associates	100.00%		(62,512)	2
3	V	26	Insurance		Halsted Terrace Associates	100.00%	41,230	41,230	3
4	V	19	Accounting		Halsted Terrace Associates	100.00%	4,692	4,692	4
5	V	21	Trust Fees		Halsted Terrace Associates	100.00%	375	375	5
6	V	32	Mortgage Interest		Halsted Terrace Associates	100.00%	618,501	618,501	6
7	V	33	Real Estate Taxes		Halsted Terrace Associates	100.00%	228,301	228,301	7
8	V	30	Depreciation		Halsted Terrace Associates	100.00%	208,205	208,205	8
9	V	31	Amortization of Loan Costs		Halsted Terrace Associates	100.00%	10,129	10,129	9
10	V	21	State Replacement Tax		Halsted Terrace Associates	100.00%	3,960	3,960	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,376,512			$ 1,115,393	$ * (261,119)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK, INC.	100.00%	$ 40,213	$ 40,213	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK, INC.	100.00%	1,411	1,411	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK, INC.	100.00%	11,418	11,418	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK, INC.	100.00%	3,560	3,560	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK, INC.	100.00%	42	42	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK, INC.	100.00%	7,052	7,052	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	71,676	CAREPATH HEALTH NETWORK, INC.	100.00%		(71,676)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 71,676			$ 63,696	$ * (7,980)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$	ITEX COMPANY / A.K. CARE	100.00%	$ 4,995	$ 4,995	15
16	V	03	HOUSEKEEPING		ITEX COMPANY / A.K. CARE	100.00%	15,363	15,363	16
17	V	05	UTILITIES		ITEX COMPANY / A.K. CARE	100.00%	4,513	4,513	17
18	V	06	REPAIRS AND MAINT.		ITEX COMPANY / A.K. CARE	100.00%	4,444	4,444	18
19	V	19	PROFESSIONAL FEES		ITEX COMPANY / A.K. CARE	100.00%	9,886	9,886	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX COMPANY / A.K. CARE	100.00%	1,920	1,920	20
21	V	21	CLERICAL AND GENERAL		ITEX COMPANY / A.K. CARE	100.00%	31,395	31,395	21
22	V	24	EDUCATION/SEMINARS		ITEX COMPANY / A.K. CARE	100.00%	2,597	2,597	22
23	V	26	INSURANCE		ITEX COMPANY / A.K. CARE	100.00%	857	857	23
24	V	27	EMPLOYEE BENEFITS		ITEX COMPANY / A.K. CARE	100.00%	1,679	1,679	24
25	V	30	DEPRECIATION		ITEX COMPANY / A.K. CARE	100.00%	25,891	25,891	25
26	V	31	AMORTIZATION		ITEX COMPANY / A.K. CARE	100.00%	276	276	26
27	V	32	INTEREST		ITEX COMPANY / A.K. CARE	100.00%	39,488	39,488	27
28	V	33	REAL ESTATE TAXES		ITEX COMPANY / A.K. CARE	100.00%	8,889	8,889	28
29	V	35	EQUIPMENT RENTAL		ITEX COMPANY / A.K. CARE	100.00%	2,904	2,904	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX COMPANY / A.K. CARE	100.00%	174,390	174,390	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX COMPANY / A.K. CARE	100.00%	55,349	55,349	33
34	V								34
35	V	19	PROFESSIONAL FEES	377,503	ITEX COMPANY / A.K. CARE	100.00%		(377,503)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 377,503			$ 384,836	$ * 7,333	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	BERNIE HOLLANDER-SAL.	$	SHAYMARK MANAGEMENT CORP.	100.00%	$ 91,594	$ 91,594	15
16	V	19	PROFESSIONAL FEES		SHAYMARK MANAGEMENT CORP.	100.00%	3,609	3,609	16
17	V	21	OFFICE		SHAYMARK MANAGEMENT CORP.	100.00%	2,217	2,217	17
18	V	27	PAYROLL TAXES		SHAYMARK MANAGEMENT CORP.	100.00%	4,509	4,509	18
19	V								19
20	V								20
21	V								21
22	V	17	MANAGEMENT FEES	300,000	SHAYMARK MANAGEMENT CORP.	100.00%		(300,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 300,000			$ 101,929	$ * (198,071)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR MANAGEMENT CORP.	100.00%	$ 5,535	$ 5,535	15
16	V	21	OFFICE		JLR MANAGEMENT CORP.	100.00%	172	172	16
17	V	27	PAYROLL TAXES		JLR MANAGEMENT CORP.	100.00%	247	247	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	180,000	JLR MANAGEMENT CORP.	100.00%		(180,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 180,000			$ 5,954	$ * (174,046)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bernard Hollander	President	Management	83.33%	See Attached	31	47.69%	Alloc. Salary	$ 91,594	17 - 07	1
2	Jack Rajchenbach	Vice President	Management	10.00%	See Attached	2	3.08%	Alloc. Salary	5,535	17 - 07	2
3	Mark Hollander	Relative	Executive		See Attached	25	41.67%	Salary	203,035	17 - 01	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 300,164		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CAREPATH FEES	629,760	13	$ 353,316	$ 353,316	71,676	$ 40,213	1
2	19	PROFESSIONAL FEES	CAREPATH FEES	629,760	13	12,396		71,676	1,411	2
3	20	FEES, SUBSCRIPTIONS	CAREPATH FEES	629,760	13	100,317		71,676	11,418	3
4	21	CLERICAL AND GENERAL	CAREPATH FEES	629,760	13	31,275		71,676	3,560	4
5	24	SEMINARS	CAREPATH FEES	629,760	13	366		71,676	42	5
6	27	GEN ADMIN.- EMP. BEN.	CAREPATH FEES	629,760	13	61,960		71,676	7,052	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 559,630	$ 353,316		$ 63,696	25

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ITEX COMPANY / A.K. CARE
Street Address: 6633 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	AVAIL. BED DAYS	462,455	5	$ 21,096	$	109,500	$ 4,995	1
2	03	HOUSEKEEPING	AVAIL. BED DAYS	462,455	5	64,883		109,500	15,363	2
3	05	UTILITIES	AVAIL. BED DAYS	462,455	5	19,061		109,500	4,513	3
4	06	REPAIRS AND MAINT.	AVAIL. BED DAYS	462,455	5	18,769		109,500	4,444	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	462,455	5	41,751		109,500	9,886	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	462,455	5	8,107		109,500	1,920	6
7	21	CLERICAL AND GENERAL	AVAIL. BED DAYS	462,455	5	132,593		109,500	31,395	7
8	24	EDUCATION/SEMINARS	AVAIL. BED DAYS	462,455	5	10,970		109,500	2,597	8
9	26	INSURANCE	AVAIL. BED DAYS	462,455	5	3,618		109,500	857	9
10	27	EMPLOYEE BENEFITS	AVAIL. BED DAYS	462,455	5	7,090		109,500	1,679	10
11	30	DEPRECIATION	AVAIL. BED DAYS	462,455	5	109,347		109,500	25,891	11
12	31	AMORTIZATION	AVAIL. BED DAYS	462,455	5	1,165		109,500	276	12
13	32	INTEREST	AVAIL. BED DAYS	462,455	5	166,773		109,500	39,488	13
14	33	REAL ESTATE TAXES	AVAIL. BED DAYS	462,455	5	37,542		109,500	8,889	14
15	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	462,455	5	12,263		109,500	2,904	15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOC.		5	708,007	708,007		174,390	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOC.		5	224,712			55,349	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,587,747	$ 708,007		$ 384,836	25

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHAYMARK MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	BERNIE HOLLANDER-SAL.	AVG. HRS. WORKED	53	5	$ 156,596	$ 156,596	31	$ 91,594	1
2	19	PROFESSIONAL FEES	AVG. HRS. WORKED	53	5	6,170		31	3,609	2
3	21	OFFICE	AVG. HRS. WORKED	53	5	3,790	3,790	31	2,217	3
4	27	PAYROLL TAXES	AVG. HRS. WORKED	53	5	7,708		31	4,509	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,264	$ 160,386		$ 101,929	25

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JLR MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HRS. WORKED	61	9	$ 168,808	$ 168,808	2	$ 5,535	1
2	21	OFFICE	AVG. HRS. WORKED	61	9	5,235		2	172	2
3	27	PAYROLL TAXES	AVG. HRS. WORKED	61	9	7,543		2	247	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 181,586	$ 168,808		$ 5,954	25

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Chase Automobile Finance		X	Automobile - Lexus	$1,343	09/21/01	$ 48,346	$ 38,840	08/21/04	7.50%	$ 1,039	1
2	Mid-America Elevator		X	Elevator	$2,998	05/24/99	148,200	71,424	05/24/04	7.90%	6,901	2
3	Hill-Rom		X	Nursing Equipment	$445	03/15/00	9,642	878	02/15/02	10.00%	362	3
4	ABB Business Finance		X	Paging System	$541	0701/01	25,393	23,390	06/01/06	10.13%	1,244	4
5	Cambridge Realty		X	Mortgage	$58,973	03/01/94	8,746,500	8,205,512	03/01/29	7.50%	618,501	5
	Working Capital											
6	American National Bank		X	Line of Credit	Various			2,000,000		4.75%	120,209	6
7	American National Bank		X	Note Payable	Various	12/06/01		1,100,000		4.75%	3,819	7
8	Insurance Financing		X								874	8
9	TOTAL Facility Related				$64,300		$ 8,978,081	$ 11,440,044			$ 752,949	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							877,925			142,106	10
11	Interest Income										(33,475)	11
12	R.P. Interest Income										(62,512)	12
13												13
14	TOTAL Non-Facility Related						$	$ 877,925			$ 46,119	14
15	TOTALS (line 9+line14)						$ 8,978,081	$ 12,317,969			$ 799,068	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Bernard Hollander	X		Working Capital			$	$ 141,432		8.00%	$ 46,409	1
2	Halsted Associates	X						0		8.00%	56,209	2
3	Glenview Terrace	X						736,493			0	3
4	Itex / A.K. Care	X									39,488	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 877,925			$ 142,106	21

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 297,851	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 265,548	2
3. Under or (over) accrual (line 2 minus line 1).		$ (32,303)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 269,493	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 237,190	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	237,211	8
	1997	280,557	9
	1998	285,569	10
	1999	283,668	11
	2000	256,659	12

Real Estate Tax Accrual = $256,659 * 1.05 = $269,493

Allocated Real Estate Taxes = $8,889

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HALSTED TERRACE NSG CTR INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0020842

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-16-316-001-000	Nursing Home	$ 25,435.92	$ 25,435.92
2.	25-16-316-002-000	Nursing Home	$ 24,420.10	$ 24,420.10
3.	25-16-332-012-000	Nursing Home	$ 83,724.35	$ 83,724.35
4.	25-16-332-013-000	Nursing Home	$ 123,079.67	$ 123,079.67
5.			$	$
6.	10-35-312-022	Home Office	$ 39,270.15	$ 8,889.25
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 295,930.19	$ 265,549.29

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,068 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 354,499
2. Number of Years Over Which it is Being Amortized: 25
3. Current Period Amortization: 10,405
4. Dates Incurred: 1995

Nature of Costs: Loan Costs = $10,129, Alloc. Itex / A.K. Care = $276
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 855,000	1
2					2
3	TOTALS			$ 855,000	3

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	750		20	-		750	9
10	Various			1979	12,807		20	201	201	12,272	10
11	Various			1980	35,915		20	-		35,915	11
12	Various			1981	13,910		20	-		13,910	12
13	Various			1982	8,814		20	-		8,814	13
14	Various			1983	12,936		20	-		12,936	14
15	Various			1984	20,560		20	-		20,560	15
16	Various			1985	18,883		20	96	96	18,637	16
17	Various			1986	2,456		20	103	103	2,033	17
18	Various			1987	4,000		20	127	127	1,829	18
19	Various			1988	82,596		20	2,621	2,621	34,653	19
20	Various			1989	1,225		20	39	39	483	20
21	Various			1990	91,597		20	3,783	3,783	37,464	21
22	Various			1993	53,620		20	2,681	2,681	25,837	22
23	Various			1995	137,949		20	7,063	7,063	44,943	23
24	Various			1996	538,107		20	26,907	26,907	163,169	24
25	Various			1997	76,548		20	3,910	3,910	17,904	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		8,591,468	219,386		421,907	202,521	3,328,459	68
69	Financial Statement Depreciation			32,819			(32,819)		69
70	TOTAL (lines 4 thru 69)		$ 9,704,141	$ 252,205		$ 469,438	$ 217,233	$ 3,780,568	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,704,141	$ 252,205		$ 469,438	$ 217,233	$ 3,780,568	1
2	FENCE	1998	2,962		20	148	148	543	2
3	FENCE	1998	3,870		20	194	194	760	3
4	MORTON FLOORS	1998	5,415		20	271	271	1,016	4
5	RADIANT HEATER	1998	2,250		20	113	113	414	5
6	FENCE	1998	1,088		20	54	54	203	6
7	FLOOR	1998	2,950		20	148	148	493	7
8	AWNING	1998	1,365		20	68	68	227	8
9	LOCKS	1998	9,001		20	450	450	1,425	9
10	LOCKS	1998	13,366		20	668	668	2,060	10
11	METAL DOOR FRAMES	1998	4,603		20	230	230	728	11
12	ELEVATOR	1998	3,480		20	174	174	638	12
13	ELEVATOR PADS	1998	1,360		20	68	68	232	13
14	ROOF	1998	4,400		20	220	220	770	14
15	PREFINISHED FRAMES	1998	1,385		20	69	69	247	15
16	KICKPLATES/HANDRAILS	1998	1,386		20	69	69	236	16
17	ROOF REPAIRS	1998	3,075		20	154	154	603	17
18	OUTLETS & FIXTURES	1998	592		20	30	30	93	18
19	FIRE DAMPER	1998	10,365		20	518	518	1,554	19
20	AIR CONDITIONERS	1998	4,575		20	229	229	1,374	20
21	FIRE DAMPER RELAY	1999	1,109		20	55	55	165	21
22	FIRE DAMPERS	1999	510		20	26	26	78	22
23	DOORS	1999	343		20	17	17	51	23
24	DOORS	1999	10,423		20	521	521	1,563	24
25	SMOKE DAMPER AND DUC	1999	1,120		20	56	56	159	25
26	FIRE DAMPERS	1999	1,188		20	59	59	167	26
27	DOOR FRAMES	1999	5,258		20	263	263	723	27
28	DOORS	1999	9,021		20	451	451	1,240	28
29	TILE	1999	1,275		20	64	64	171	29
30	LOCKS	1999	8,033		20	402	402	1,197	30
31	TILE	1999	1,220		20	61	61	158	31
32	FIRE DAMPER&DUCT WOR	1999	2,025		20	101	101	261	32
33	FENCE	1999	1,100		20	55	55	142	33
34	TOTAL (lines 1 thru 33)		$ 9,824,254	$ 252,205		$ 475,444	$ 223,239	$ 3,800,259	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,824,254	$ 252,205		$ 475,444	$ 223,239	$ 3,800,259	1
2	SPRINKLER HEADS	1999	850		20	43	43	108	2
3	SINKS & TOILETS	1999	1,275		20	64	64	160	3
4	WALL LIFHTS & RECEPT	1999	1,314		20	131	131	328	4
5	SPRINKLER HEAD	1999	550		20	28	28	70	5
6	COVE BASE STOOPS	1999	956		20	48	48	116	6
7	LANDSCAPING	1999	2,790		20	140	140	315	7
8	AWNINGS	1999	3,943		20	197	197	509	8
9	BASEBOARD	1999	1,055		20	53	53	137	9
10	CLOSETS	1999	1,729		20	86	86	222	10
11	CLOSETS	1999	692		20	35	35	90	11
12	ELEVATOR	1999	114,600		20	5,730	5,730	14,803	12
13	BASEBOARDS	1999	1,631		20	82	82	178	13
14	DOORS	1999	27,168		20	1,358	1,358	2,942	14
15	DOOR FRAMES	1999	2,171		20	109	109	236	15
16	LOCKS & KEYS	1999	6,858		20	343	343	743	16
17	BASEBOARDS	1999	1,078		20	54	54	117	17
18	FIRE ALARM & RELAYS	1999	1,263		20	63	63	131	18
19	CEILING TILE	1999	8,496		20	425	425	956	19
20	KITCHEN EXHAUST	1999	755		20	38	38	105	20
21	STEAMER	1999	705		20	35	35	85	21
22	CHILLERS	1999	993		20	50	50	125	22
23	SMOKE DETECTOR	1999	726		20	36	36	102	23
24	COOLER	1999	602		20	30	30	75	24
25	HOSES	1999	524		20	26	26	65	25
26	DRAIN LINES	1999	1,400		20	70	70	175	26
27	WIRING	1999	1,344		20	67	67	145	27
28	CARPET	1999	10,811		20	541	541	2,072	28
29	ELECTRICAL FIXTURE	1999	563		20	28	28	121	29
30	WINDOW TREATMENTS	1999	1,864		20	93	93	326	30
31	WALLCOVERING	1999	2,473		20	124	124	392	31
32	FLOURESCENT FIXTURES	1999	2,756		20	138	138	437	32
33	CARPET	1999	1,605		20	80	80	268	33
34	TOTAL (lines 1 thru 33)		$ 10,029,794	$ 252,205		$ 485,789	$ 233,584	$ 3,826,913	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,029,794	$ 252,205		$ 485,789	$ 233,584	$ 3,826,913	1
2	WALL COVERINGS	1999	600		20	30	30	120	2
3	FLOURESCENT FIXTURES	1999	2,253		20	113	113	357	3
4	CUSTOM NURSING STATI	1999	6,700		20	335	335	1,284	4
5	WALLCOVERINGS	1999	20,218		20	1,011	1,011	4,381	5
6	WALLCOVERINGS	1999	636		20	32	32	139	6
7	ROOF REPAIRS	2000	7,143		20	183	183	336	7
8	HEAT EXCHANGER	2000	1,942		20	97	97	194	8
9	FLORESCENT FIXTURES	2000	2,014		20	101	101	202	9
10	FLOURESCENT FIXTURES	2000	1,488		20	74	74	148	10
11	FLOURESCENT FIXTURES	2000	2,911		20	146	146	280	11
12	FLOURESCENT FIXTURES	2000	3,307		20	165	165	316	12
13	WALLCOVERING	2000	1,352		20	68	68	125	13
14	WALLCOVERING	2000	1,415		20	71	71	130	14
15	TILE	2000	1,981		20	99	99	173	15
16	TILE	2000	760		20	38	38	67	16
17	SPRINKLER HEAD	2000	878		20	44	44	66	17
18	A/C REPAIRS	2000	12,021		20	601	601	851	18
19	FLOURESCENT FIXTURES	2000	494		20	25	25	29	19
20	ELEVATOR REPAIR	2000	1,393		20	70	70	117	20
21	SPRINKLER SYSTEM	2000	1,000		20	50	50	96	21
22	SPRINKLER RINGS	2000	564		20	28	28	47	22
23	SWITCHES	2000	525		20	26	26	37	23
24	FREEZER	2000	571		20	29	29	39	24
25	PUMP	2000	521		20	26	26	33	25
26	BOILER	2000	1,150		20	58	58	73	26
27	SPRINKLER RINGS	2000	1,316		20	66	66	105	27
28	EXTERIOR INSULATION	2000	511		20	26	26	37	28
29	TMX AND LMX CARDS	2000	1,519		20	76	76	152	29
30	MODEM HOOKUP	2000	1,617		20	81	81	149	30
31	VOICEMAIL INSTALL	2001	1,229		20	16	16	16	31
32	ELECTRICAL WORK	2001	696		20	9	9	9	32
33	BOILERS	2001	56,500		20	471	471	471	33
34	TOTAL (lines 1 thru 33)		$ 10,167,019	$ 252,205		$ 490,054	$ 237,849	$ 3,837,492	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,167,019	$ 252,205		$ 490,054	$ 237,849	$ 3,837,492	1
2	PAGING SYSTEM	2001	25,443		20	636	636	636	2
3	WALLCOVERINGS	2001	754		20	32	32	32	3
4	LIGHT FIXTURES	2001	522		20	11	11	11	4
5	ELEVATOR FLOORING	2001	597		20	28	28	28	5
6	ELEVATOR FLOORING	2001	784		20	36	36	36	6
7	PAINTING	2001	3,779		20	95	95	95	7
8	BOOSTER POWER SUPPLY	2001	876		20	11	11	11	8
9	AC REPAIR	2001	2,397		20	80	80	80	9
10	SPRINKLER REPAIR	2001	1,014		20	34	34	34	10
11	HANDRAIL	2001	600		20	15	15	15	11
12	HOT WATER VALVE REPA	2001	850		20	18	18	18	12
13	HOT WATER VALVE REPA	2001	1,419		20	18	18	18	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,206,054	$ 252,205		$ 491,068	$ 238,863	$ 3,838,506	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 10,206,054	$ 252,205		$ 491,068	$ 238,863	$ 3,838,506	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,206,054	$ 252,205		$ 491,068	$ 238,863	$ 3,838,506	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 10,206,054	$ 252,205		$ 491,068	$ 238,863	$ 3,838,506	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,206,054	$ 252,205		$ 491,068	$ 238,863	$ 3,838,506	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 10,206,054	$ 252,205		$ 491,068	$ 238,863	$ 3,838,506	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,206,054	$ 252,205		$ 491,068	$ 238,863	$ 3,838,506	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 10,206,054	$ 252,205		$ 491,068	$ 238,863	$ 3,838,506	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,206,054	$ 252,205		$ 491,068	$ 238,863	$ 3,838,506	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1994		$ 7,334,294	$ 205,099	20	$ 366,715	$ 161,616	$ 2,903,160	4
5			1993		379,807	9,739	35	10,852	1,113	93,142	5
6											6
7											7
8											8
	Improvement Type**										
9	HALSTED ASSOCIATES		1994		791,085	2,443	20	40,036	37,593	298,793	9
10	ITEX / A.K. CARE - VARIOUS		1993		47,791	577	20	2,390	1,813	20,804	10
11	ITEX / A.K. CARE - VARIOUS		1994		25,669	935	20	1,273	338	9,346	11
12	ITEX / A.K. CARE - VARIOUS		1995		4,375	361	20	219	142	1,356	12
13	ITEX / A.K. CARE - VARIOUS		1996		248	22	20	12	(10)	75	13
14	ITEX / A.K. CARE - VARIOUS		1997		7,380	189	20	369	180	1,660	14
15	ITEX / A.K. CARE - VARIOUS		1999		819	21	20	41	20	123	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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48									48
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60									60
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,591,468	$ 219,386		$ 421,907	$ 202,805	$ 3,328,459	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,587,547	$ 86,525	$ 156,553	$ 70,028	10	$ 995,376	71
72	Current Year Purchases	20,624	25,554	1,504	(24,050)	10	1,504	72
73	Fully Depreciated Assets	619,477				10	619,477	73
74								74
75	TOTALS	$ 2,227,648	$ 112,079	$ 158,057	$ 45,978		$ 1,616,357	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2001 LEXUS	2001	$ 25,000	$ 811	$ 1,131	$ 320	5	$ 1,131	76
77										77
78										78
79										79
80	TOTALS			$ 25,000	$ 811	$ 1,131	$ 320		$ 1,131	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,313,702	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 365,095	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 650,256	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 285,161	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,455,994	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	AUTO LEXUS - 2001	$ 124,017	$ 4,024	$ 4,024	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 124,017	$ 4,024	$ 4,024	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage				2,477			5
6								6
7	TOTAL				$ 2,477 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 18,893 Description: Water Cooler - $1,654, Postage Meter - $747, Carbon Filters - $1,698, Copy Machine - $11,891, Itex = $2,904
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Multiple Vehicles	$ 510	$ 17,686	17
18	Non-Allowalbe Expense			(17,686)	18
19					19
20					20
21	TOTAL		$ 510	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01, 39 - 03	hrs	$ 42,056		$ 15,692	$		$ 57,748	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,396			2,396	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01, 39 - 03	hrs	90,660		28,231			118,891	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				128,384		128,384	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						42,632		42,632	13
14	TOTAL			$ 132,716		$ 46,319	$ 171,016		$ 350,051	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,000	$ 226,117	1
2	Cash-Patient Deposits	143,475	143,475	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,845,712	2,845,712	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		1,100,000	5
6	Prepaid Insurance	208,151	218,431	6
7	Other Prepaid Expenses	24,546	24,546	7
8	Accounts Receivable (owners or related parties)	639,118	634,571	8
9	Other(specify): See supplemental schedule	14,067	643,194	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,876,069	$ 5,836,046	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		855,000	13
14	Buildings, at Historical Cost		7,998,898	14
15	Leasehold Improvements, at Historical Cost	2,926,525	2,961,421	15
16	Equipment, at Historical Cost		905,642	16
17	Accumulated Depreciation (book methods)	(1,792,172)	(4,320,095)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		354,499	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(80,187)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	455,478	455,478	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,589,831	$ 9,130,656	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,465,900	$ 14,966,702	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,161,199	$ 1,219,982	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	163,980	163,980	28
29	Short-Term Notes Payable	4,023,924	4,023,924	29
30	Accrued Salaries Payable	211,370	211,370	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,680	32,680	31
32	Accrued Real Estate Taxes(Sch.IX-B)		269,493	32
33	Accrued Interest Payable			33
34	Deferred Compensation	90,000	90,000	34
35	Federal and State Income Taxes		3,961	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	554,106	554,106	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,237,259	$ 6,569,496	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	88,533	88,533	39
40	Mortgage Payable		8,205,512	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 88,533	$ 8,294,045	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,325,792	$ 14,863,541	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (859,892)	$ 103,161	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,465,900	$ 14,966,702	48

*(See instructions.)

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,556,353)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,556,353)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	696,461	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 696,461	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (859,892)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,540,242	1
2	Discounts and Allowances for all Levels	(592,992)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,947,250	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	681,275	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 681,275	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	760	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	110	15
16	Rental of Facility Space		16
17	Sale of Drugs	169,586	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	56,616	19
20	Radiology and X-Ray		20
21	Other Medical Services	87,018	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 314,090	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	33,475	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 33,475	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	48,456	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 48,456	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,024,546	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,683,455	31
32	Health Care	3,916,677	32
33	General Administration	3,382,596	33
	B. Capital Expense		
34	Ownership	1,722,241	34
	C. Ancillary Expense		
35	Special Cost Centers	458,866	35
36	Provider Participation Fee	164,250	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,328,085	40
41	**Income before Income Taxes (line 30 minus line 40)****	696,461	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 696,461	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,973	2,086	$ 71,624	$ 34.34	1
2	Assistant Director of Nursing	1,973	2,104	51,112	24.29	2
3	Registered Nurses	18,386	20,773	430,780	20.74	3
4	Licensed Practical Nurses	67,185	75,648	1,330,027	17.58	4
5	Nurse Aides & Orderlies	146,522	159,650	1,248,879	7.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,978	4,032	132,716	32.92	7
8	Rehab/Therapy Aides	11,154	12,999	129,672	9.98	8
9	Activity Director	1,941	2,086	22,039	10.57	9
10	Activity Assistants	21,568	23,925	176,874	7.39	10
11	Social Service Workers	7,022	7,795	94,957	12.18	11
12	Dietician					12
13	Food Service Supervisor	1,719	2,156	25,173	11.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,643	36,283	248,719	6.85	15
16	Dishwashers					16
17	Maintenance Workers	7,166	7,893	96,267	12.20	17
18	Housekeepers	42,792	46,655	335,912	7.20	18
19	Laundry	7,727	8,333	52,520	6.30	19
20	Administrator	2,029	2,086	81,050	38.85	20
21	Assistant Administrator					21
22	Other Administrative	1,300	1,300	203,035	156.18	22
23	Office Manager	1,948	2,086	40,192	19.27	23
24	Clerical	16,395	18,044	236,860	13.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,819	2,084	26,288	12.61	31
32	Other Health Care(specify)					32
33	Other(specify)	3,500	3,809	107,495	28.22	33
34	TOTAL (lines 1 - 33)	401,740	441,827	$ 5,142,191 *	$ 11.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	321	$ 13,071	01-03	35
36	Medical Director	Monthly	21,800	09-03	36
37	Medical Records Consultant	Monthly	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,928	10-03	39
40	Physical Therapy Consultant	49	2,425	10a-03	40
41	Occupational Therapy Consultant	18	1,306	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	18	875	10a-03	43
44	Activity Consultant	Monthly	2,400	11-03	44
45	Social Service Consultant	52	3,076	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	458	$ 54,913		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joelynn Miller-Johnson	Administrator	0	$ 81,050
Mark Hollander	Executive	0	203,035
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 284,085

B. Administrative - Other

Description	Amount
Management Fees - JLR Management	$ 180,000
Management Fees - Shaymark	300,000
Management Fees - Bernard Cohen & Associates	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 540,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
A.K. Care	Data Processing	$ 1,903
A.K. Care	Bookkeeping / Accounting	375,600
Healthcare Horizons	Administrative Consultant	10,227
CarePath	Bookkeeping	71,676
Power Software	Computer Consultant	11,089
JAHCO	Accredidation	3,495
Personnel Planners	Unemployment Consultant	3,025
Susan Fox	Accounting	14,940
Frost, Ruttenberg & Rothblatt	Accounting	74,639
Commitment Consulting	Accounting	25,943
Cox, Ltd.	Architectural / Appraisal	1,596
See Attached Summary	Legal	24,944
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 619,077

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,533
Unemployment Compensation Insurance	73,324
FICA Taxes	384,355
Employee Health Insurance	210,405
Employee Meals	33,690
Illinois Municipal Retirement Fund (IMRF)*	
Head Tax	9,540
Pension / Savings Plans	41,327
Miscellaneous Employee Benefits	2,005
Christmas Expense	11,639
TOTAL (agree to Schedule V, line 22, col.8)	$ 863,818

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	7,673
Health Care Worker Background Check	6,414
(Indicate # of checks performed 599)	
Public Relations	129,640
Advertising / Yellow Page Directories	3,946
Association Dues - ICLTC	12,844
Licenses	1,234
Dues and Subscriptions	721
Alloc. - Itex / A.K. Care / CarePath	13,338
Less: Public Relations Expense	(129,640)
Non-allowable advertising	
Yellow page advertising	(3,946)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,424

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,425
Non-Allowable	(179)
Alloc. Itex / A.K. Care / CarePath	2,639
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,885

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $12,844**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **86,376** Line **10 - 02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **164,250**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **33,690** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees